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ABSTRACT

This publication is a compilation of highlights from papers presented at the Associate Degree Nursing (ADN) project's regional conferences during 1983-84. Papers address pertinent issues in ADN education and practice. "AD Education: Are the Parameters Real?" (Julia Perkins) examines the parameters of associate degree nursing education from a historical perspective, in terms of what the literature says regarding the parameters of this type of education and practice, and by performance and use of graduates. "Transition Shock" (Anastasia Hartley) discusses the need for cooperative planning between education and service personnel to ease transition into the workplace. "AD Education: Parameters Espoused and in Use" (Georgeen H. DeChow and Jo C. Pierce) discusses the espoused parameters (what educators say) and describes those in use (what educators do). "Expectations of AD Graduates: An Educator's Perspective" (Sarah L. Etkin) uses the competency statements and premises of the National League for Nursing to describe the expected characteristics of ADN practice. "Bridges to Success" (Ann Larowe) also examines the parameters and philosophyy of AD education. "A Competency-Based Curriculum: Process at Kennesaw College" (Ann Crutchfield and Vanice W. Roberts) describes the process of competency development in the AD program. "Performance Differences in Graduates of Associate and Baccalaureate Degree Programs" (Annette Bairan, Leslie Brown, Pamela Chally, and Beverly Farnsworth) reports findings from a study conducted at the University of Vermont to demonstrate performance differences of graduates from AD programs versus baccalaureate programs. "Proposed Solutions to Issues in ADN" (Zeila W. Bailey and Dorothy Scott) suggests improvements for ADN education. "Expectations of AD Graduates: A Nursing Service Director's Perspectives" (Jacqueline Mardan) cites necessary skills and standards of performance. "The Reality of the Workplace" (Mona Raborn) stresses the need for leadership training. "An Educational Clinical Preceptorship" (Marianne Crouse, Emily Slunt, and Brenda Carter) and "An Internship Program" (Frances E. Casillo) describe these programs. "AD/BSN Competency Differentiation" (S. Joan Gregory) compares competencies of nurses from AD and Bachelor of Science in Nursing programs. "Opportunities for Success in the 80s" (Katherine Vestal) considers nurse utilization in a changing health care environment. "Clinical Competence Validation" (Carol Singer) summarizes a method of validating clinical competence of AD students. A bibliography concludes the document. (YLB)

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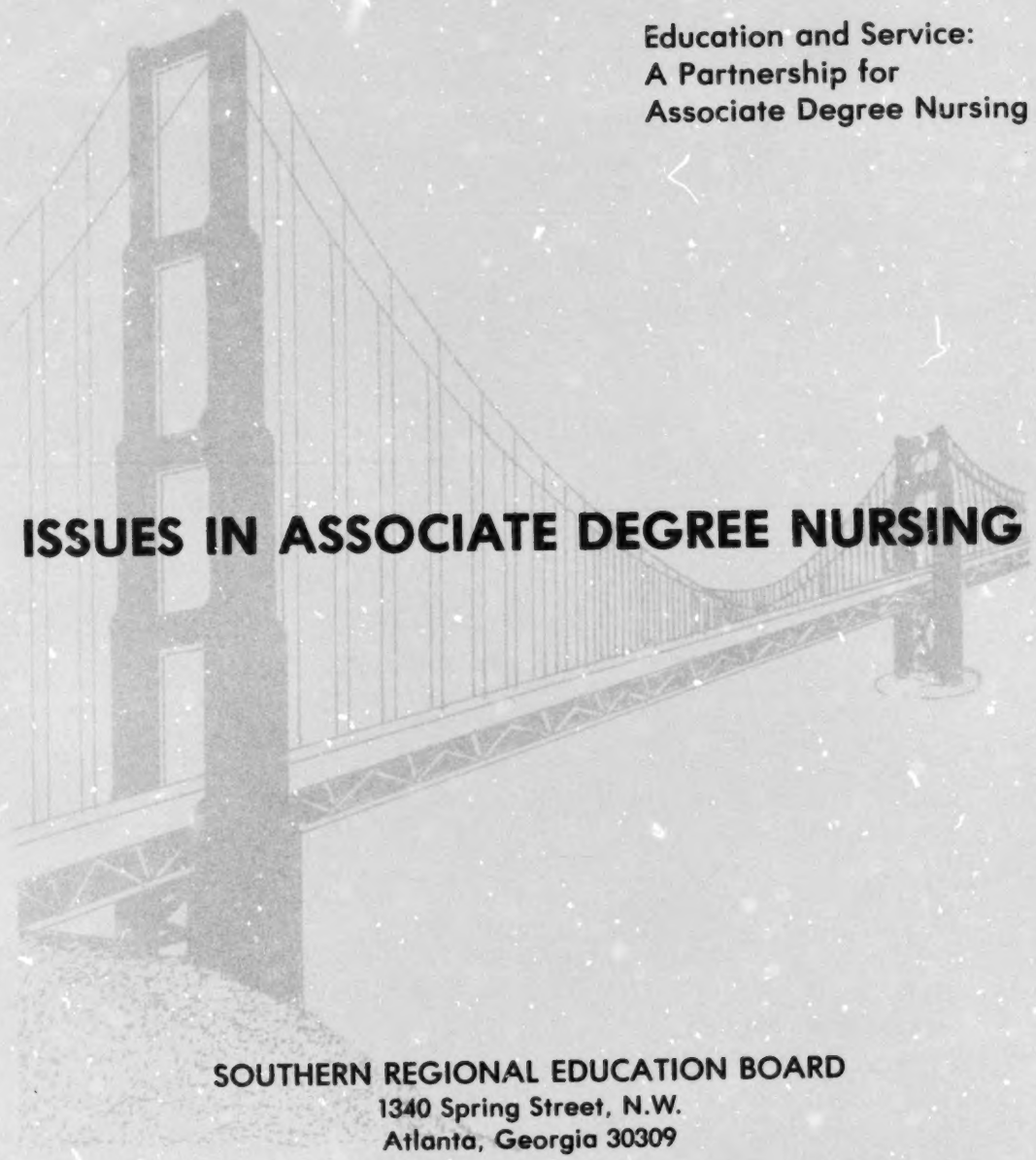
BRIDGE TO SUCCESS

Education and Service: A Partnership for Associate Degree Nursing



ISSUES IN ASSOCIATE DEGREE NURSING

SOUTHERN REGIONAL EDUCATION BOARD
1340 Spring Street, N.W.
Atlanta, Georgia 30309

1984

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FOREWORD

The Associate Degree Nursing (ADN) project administered by the Southern Regional Education Board (SREB) is part of a nationwide effort, funded by the W. K. Kellogg Foundation of Battle Creek, Michigan, directed toward bridging the gap between associate degree nursing education and practice. The overall goals are to: (1) insure competence of faculty in ADN programs, (2) assure strong clinical skills of ADN graduates, (3) improve working relationships between service and education personnel, and (4) develop shared and reasonable expectations for performance of beginning nurses.

The SREB endeavor consists of a series of continuing education activites for associate degree nursing faculty and nursing service personnel. These activities, to be conducted during a three-year project period (1982-1985), are directed by a regional center (SREB) and six demonstration centers. Two coordinators, an ADN educator and a nursing service representative, are responsible for activities at each of the demonstration centers. Six associate degree nursing programs* were selected by SREB to serve as demonstration centers and to conduct a total of 48 workshops for teams of ADN educators and nursing service personnel on curriculum development and methods to ease transition of graduates into practice settings. SREB will plan and conduct a total of 12 one-day conferences that address pertinent issues in ADN education and practice.

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* The programs are: University of Arkansas at Little Rock, El Centro College (Dallas, Texas), Hinds Junior College (Jackson, Mississippi), Howard Community College (Columbia, Maryland), Manatee Junior College (Bradenton, Florida), University of South Carolina at Aiken.

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INTRODUCTION

Production and utilization are key concepts that characterize some of the issues in associate degree (AD) nursing. These concepts relate to the preparation and use of associate degree graduates. Does the product meet the demands of the marketplace? What does the educator expect? What does the marketplace require?

The dilemma is not new; it has existed for nearly two decades. A review of the literature documents the deliberation and the various responses of education and service personnel to alleviate the problems.

In an effort to insure a proper fit of the graduate in the workplace, some educators added transitional and leadership courses; service personnel developed orientation programs of varied purposes, lengths, and intensities. National and regional activities were initiated to define the role and expected competencies of the associate degree graduate (AD) and to demonstrate that these nurses could perform at an optimum level, given time to learn the workplace. For example, both the National League for Nursing and the SREB Nursing Curriculum Project have explored the education-service relationship of AD graduates.

Although these activities did not resolve the mismatch of the goals of education and the requirements of the marketplace, they did help education and service personnel become aware of the special needs and problems in each setting and to recognize the benefits of cooperating to achieve common objectives. Continued collaboration between education and service personnel will be critical elements in the delivery of quality patient care in the next decades.

This publication is a compilation of papers presented at the ADN project's regional conferences during 1983-84. It contains highlights from the discussions of the parameters and philosophy of associate degree nursing education, the expectations of the AD graduate in practice settings, the needs of educational and work settings, and methods to ease transition of AD graduates into the workplace. The conferences provided a forum for lively discussions and exchange of ideas. Although it is not possible to capture the dynamic interactions, it is anticipated that the dissemination of information in this publication will be helpful to AD education and nursing service personnel throughout the region. Readers are encouraged to contact the contributors for additional information about a particular subject.

AD EDUCATION: ARE THE PARAMETERS REAL?

Julia Perkins, Chairman, Department of Nursing at Kennesaw College (Marietta, Georgia), asked—Are the parameters of associate degree nursing education real? What parameters, if any, distinguish the associate degree graduate from graduates of other types of programs? What are the distinguishing characteristics of the educational program? Are these characteristics transferred into practice settings? She examined the parameters of associate degree nursing education from a historical perspective, in terms of what the literature says regarding the parameters of this type education and practice and by performance and utilization of graduates.

The postwar years provided a fertile climate for change. Mildred Montag and the associate degree nursing program became the cutting edge for much of the change in nursing education. Technological advances brought about by the war changed the work world creating a new type worker--the technician. Community colleges developed educational programs for technicians in a variety of fields. Negotiations began between the American Association of Junior Colleges and the National League for Nursing to explore the education of nurses within this setting. Hence, it was against this background that Montag developed a proposal for a new nursing program, Education of the Nursing Technician. This program would be centered in the college, and decisions regarding the program would be made by college personnel. Curriculum, rather than being geographically based, would be based on what nurses do, i.e., address patient problems. This idea of a conceptually based curriculum was a radical departure from the then current practice.

Another radical departure was in relation to students. The doors of nursing were opened to a new group of students--older, married, more settled men and women. Student load was to be no different for nursing than for other students. Faculty were to be hired, evaluated, and promoted on the same criteria as other faculty within the college. These reforms are now so accepted that it is difficult to imagine that it was ever different.

The idea became a national phenomena. The nursing technician concept was based on analysis of practice Montag described as follows:

> The function of nursing can be said to be on a continuum or to have spectrum-like range. At one extreme of the range of the spectrum are those activities which are very simple and which serve to give assistance to the nurse or the physician. . . .At the other extreme of the range of the function are those activities which are extremely complex and which require a high degree of skill acquired through long periods of training. . . .The main volume of nursing in hospitals, clinics and other agencies lies somewhere in between the two extremes just described. They occupy the middle of the spectrum range--and may be described as semiprofessional or technical (Montag, 1959).

Although the terminology has changed over the years from "technical nurse" to "associate degree nurse," the issue for nursing education has remained the same. What are the parameters that define the practice of this associate degree graduate? Montag defined the functions of the associate degree nurse as: (1) to assist in the planning of nursing care for patients, (2) to give general nursing care with supervision, and (3) to assist in the evaluation of nursing care given (Burnside, 1974). The original assumption was that the graduate was a generalist and working under the supervision of a professional nurse.

Educators quickly found that these early broad guides gave little direction for the selection of learning experiences that are appropriate for these students. A number of authors (Chater, 1969, 1970; Matheny, 1969; DeChow, 1969; Waters, 1978; Moore, 1969; McDonald and Harms, 1966; Johnson, 1966; Robischon, 1972; Chioni and Schoen, 1970; Michelmore, 1977) attempted to look theoretically at the practice of associate degree graduates. The practice is most often described in comparison with practice of professional or baccalaureate degree graduates. The culmination of these efforts are the statements of the American Nurses' Association (Educational Source Book, 1981) and the National League for Nursing (Competencies, 1978) which describe in detail the competencies of different types of practice. Waters (1978) proposed a framework for the examination of these parameters that consists of the following elements:

Definition of the client. Educators generally agree on the definition of the appropriate client for the associate degree nurse--the individual. Although the associate degree graduates deal with groups of patients, they deal with them on an individual basis. Even though the family members are often involved, services are related to the experience that the individual is having and the impact of his illness on relationships with others. In contrast, the baccalaureate degree graduate defines the client to mean not only an individual but groups as well. Another parameter of the appropriate client for the associate degree graduate was addressed by Waters (1978), who stated that the competence of the associate degree graduate is confined to those clients who are at home in the dominant culture of the nurse and the health care delivery system of the community in which the program resides. Baccalaureate graduates are expected to be familiar with a broader range of cultures.

Problems. The associate degree graduate is expected to address common, recurring problems that have predictable outcomes. These problems can be either physiological or psychological in nature.

Interventions. Interventions have been characterized as those which are commonly used by registered nurses with patients who are diagnosed and under care in the health care system (Waters, 1978). The interventions follow established protocols (ANA, 1980) and have predictable results (DeChow, 1969).

Context. The setting must be one where a nursing service is estalished and structured and the needs and demands for nursing are visible and defined (Waters, 1978). This premise is supported by NLN competency statements (NLN, 1978) and ANA statements (1980) that describe the practice as limited to secondary care institutions or acute or extended care institutions.

Working Relationships. New ideas have evolved since the original formulations by Montag. The associate degree graduates should work under the guidance of a person with greater expertise and be able to direct others in the performance of patient care (ANA, 1980; NLN, 1978). The management role of the associate degree graduate is limited to seeing that the client gets the care needed.

Goals for Care. A review of the literature shows more dissent regarding goals for nursing care at the associate degree level. The NLN competency statement (1978) and Waters (1978) limited the goals to illness problems as opposed to health problems. Chater (1970) limited associate degree practice to short term or immediate goals and reactions.

It is apparent that much work has gone into the delineation of these parameters. Additionally, these same parameters have been widely adopted for use in curriculum decisions. How useful are they in practice? Do they indeed define realistic parameters of practice? Are the commonalities greater than the differences?

Perkins provided some comparisons of the expectations of the associate degree graduate and the baccalaureate degree graduate. She also noted commonalities of practice. She asserted that technical and professional practice, or associate and baccalaureate practice, are not viewed as discrete entities but as one entity encompassing the other. There is a common core of practice. The nursing process is central to all levels of nursing practice. In addition, all graduates should have a core of well-developed basic nursing skills. All graduates must be accountable for their own actions within their level of expertise and for contributing to the overall quality of nursing care. These graduates, moreover, participate in the roles of caregiver, communicator, teacher, manager, member of a profession or discipline, and investigator.

The parameters, according to Perkins, are real. They encompass the parameters of practice as they are realistically encountered by the beginning practitioner in hospitals, the institutions that employ the largest numbers of nurses.

TRANSITION SHOCK

Anastasia Hartley, Former Chairman, Department of Nursing, St. Petersburg College (Florida), pointed out the need to refocus our thinking from forced technology, with all its past results, to the different interpretation of "high tech/high touch." Nursing, she indicated, must reflect the moves from short term to long term, from centralization to decentralization, from institutional help to self-help, from hierarchies to networking, from north to south movement, and from either/or thinking to multiple option thinking.

The megatrends influencing nursing--in service and education--are characterized by the effects of inflation, supply and demand of nurses, the diagnostic related groups (DRGs), and the systems approach to health care delivery and education. During the last three decades, health care delivery to citizens in this country has undergone dramatic changes. These changes have been very sporadic and, at times, resulted in quantum leaps for nursing service and nursing educational delivery systems. The "gap," therefore, between nursing service and nursing education is not a new phenomenon. It existed in the diploma schools and remains evident in the educational programs today.

The old dependency relationships between nursing service and nursing education changed radically once the differences in purposes and objectives were accepted. The bright, young graduates of the past knew the system, the power structure, and the staff on a personal basis because they were had been already oriented to the system. Upon graduation they were an integral part of a closed system. However, this system did not survive. Hence, difficulties in recruiting and retaining nurses developed as new graduates entered the system without this kind of "orientation."

In general, the expectations of the new nurse graduates are unrealistic. This almost universal pattern pervades the practice of nursing. The excessive expectation of the novice worker--from student to super nurse--is unequaled in the employment of workers in other disciplines, with the possible exception of medicine.

Cooperative planning between education and service personnel can ease the transition shock of many graduates. It can help educators and service personnel develop more realistic expectations of the graduates in the workplace. Collaboration may take place during the negotiation of contracts, meetings of advisory committees, and the development of specific programs aimed to help the novice worker enter the work force more easily, e.g., work-study programs, internships, individualized transition programs, a mini-practicum. These activities provide opportunities for education and service personnel to discuss the goals of the educational program, the demands of the workplace, and the appropriate "fit" of the AD graduate. The challenge for educators and service personnel is to expend their energies toward common goals, recognizing the need to balance and interface these systems with a mimimum of friction.

AD EDUCATION: PARAMETERS ESPOUSED AND IN USE

The parameters of AD education were examined by two other educators in terms of those espoused and those in use. A basis for this discussion was the work of Argyris and Schon (1974) who define espoused theories as those that are communicated to others and theories in use as the ones that govern actual behavior. Thus, the parameters of AD education espoused (what educators say) and those in use (what educators do) were described within this context. Georgeen H. DeChow, Assistant Dean, Manatee Junior College (Bradenton, Florida), discussed the espoused parameters; Jo C. Pierce, Chairman, Department of AD Nursing, Alcorn State University (Natchez, Mississippi), directed attention to the application of the AD parameters in a rural setting.

DeChow gave a historical perspective of the associate degree program, which was initiated to prepare a person in a different educational setting for a different scope of practice in nursing. This program, designed by Mildred Montag and studied as part of a five-year research project, removed the educative process from the service situation--the hospital--where education was too often the by-product and placed it in a college setting where service became the by-product. This move put the education of nurses under educational auspices and gave the educational group control of student time. It also changed the format of instruction. Instead of a fragmented curriculum (so common in diploma programs), watered-down doctors' lectures, and nursing content organized around diseases and procedures, the AD curriculum was developed around broad area nursing courses with carefully selected learning experiences in the clinical setting.

The original seven AD programs that were a part of the Cooperative Research Project demonstrated that students enrolled in these programs could learn what was needed to pass the licensing examination and function effectively in the hospital setting. This project validated the AD program as an appropriate and sound educational program in which to prepare a bedside nurse in a two-year period. The graduate would be a registered nurse who was, after appropriate orientation, capable of functioning effectively under the direction of a nurse with more advanced preparation. This program offered potential promise to meeting the need for more qualified nurses in the late Fifties.

The potential of the AD program to meet the need for more qualified nurses was recognized by the W. K. Kellogg Foundation of Battle Creek, Michigan. The Foundation provided the funds that helped to facilitate an increase in the number of AD programs nationally. It awarded grants to demonstration centers in community/junior college systems in New York, California, Texas, and Florida. These states were selected because each had a community college system or a developing community college system in place. Each center received funding to develop successful AD programs and to provide consultation services to other newly developing AD programs in the state or region in which it was located.

Manatee Junior College (Bradenton, Florida) was one of the demonstration centers funded in 1958. It provided on-site learning opportunities for AD faculty and consultation services to newly developing AD programs. In addition, the AD nursing faculty at Manatee Junior College offered summer workshops for five years at the University of Tennessee in Memphis. (The latter activity was funded through a grant awarded to the Southern Regional Education Board by the W. K. Kellogg Foundation.)

It was no easy task to: (1) design an educationally sound two-year nursing program that would provide the graduate with the skills and knowledge needed to begin practice, and (2) promote acceptance of the graduates by employers. Nevertheless, the development of educationally sound programs was accomplished. The parameters of AD education are stated clearly in the six major categories proposed by Waters (1978): client, problems, intervention, context of practice, work-world relationships, and goals for nursing care. These are useful guideposts in curriculum development for the AD program.

The more difficult task has been getting employers to accept and use the new graduate in appropriate roles. Acceptance increased as more AD graduates entered the work force and demonstrated clinical competence. The role envisioned for the AD graduate has not changed. However, changes in those activities associated with the registered nurse in hospital settings have necessitated modification in the knowledge base and performance expectation. These changes demand clarification of the role of the professional nurse.

Are there parameters that distinguish the associate degree graduate from the graduates of other types of programs? Although one may not find definitive parameters in the literature, the differences are real. The differences are manifest in the educational preparation and utilization of the graduates. The roles of the AD and baccalaureate graduates can emerge and compliment each other. However, the work environment must provide opportunities for these two differently prepared graduates to function in a setting in which the roles will be differentiated. The development of an additional credential for the baccalaureate nurse at the state level is a needed step in this role differentiation. The advent of Diagnostic Related Groups (DRGs) may offer nursing the opportunity to use two differently prepared graduates in providing better nursing care at no greater cost. Educators and service personnel can use this opportunity to make decisions together about what an educational program must accomplish and service will provide for the new graduates.

DeChow urged educators to be aware of the needs and demands of the marketplace in order to avert an oversupply of graduates. She suggested careful analysis of the community needs and resources before expanding or creating new programs of nursing.

Pierce administers a program based in a land-grant university located near the Mississippi River--100 miles southwest of Jackson, Mississippi, and 90 miles northeast of Baton Rouge, Louisiana. The enrollment of the AD program is approximately 90 students who are local commuter residents. (Six faculty provide the instruction.)

The needs of the graduate in primarily rural settings differ from those in urban settings. Determinants of this difference include the size of the health care settings and the specific needs of clients encountered in the agencies. Using the scope of practice outlined by DeChow, Pierce described the application of the parameters espoused in the curriculum of Alcorn State University.

Client. The client population for this program and its graduates are primarily white and black, with a small number of Jewish and Asian individuals. During March and December, there is a transient tourist population.

Problems. The problems are common and recurring with predictable outcomes. Since the major industries in this area are tourism, agriculture, wood processing, and petrochemicals, client problems generally stem from association with these industries and ethnic/cultural patterns peculiar to rural societies. Amputations from logging accidents, stress-induced ulcers, and leukemia are some of the common problems encountered.

Intervention. The main concept underlying interventions is basic human needs. The nursing process format is used by students and graduates.

Context. The AD program at Alcorn State University prepares graduates for work at the secondary care level. Graduates are employed in health care settings with a 50- to 210-bed capacity.

Relationships. Program objectives infer the preparation of graduates to work under the guidance of a more experienced person. In reality, the graduates are expected to assume leadership roles after only a short time in staff nurse roles. The AD graduates outnumber baccalaureate graduates in this area. For example, in a 50-bed hospital used for some clinical experiences only, one baccalaureate graduate is employed as a head nurse; seven of the registered nurses present at a meeting in this facility were AD graduates. This trend is observed in many of the rural agencies.

The AD faculty added to the curriculum units in communicating with peers and subordinates, management guidelines, and a specific head nurse/charge nurse transition practicum to the curriculum to "bridge the gap." This represents a discrepancy in the parameters espoused and those in use. However, the observed mismatch is probably less of a problem because of the close working relationship between the AD faculty and staff in the community agencies.

AD faculty meet on a regular basis with head nurses and supervisors of each major agency to discuss areas of mutual concern regarding protocols in use by the health care agency and the department of nursing education. The agencies send representatiaves to curriculum committee meetings; faculty attend nursing administrative affairs committee meetings at local agencies.

Goals. The purposes and objectives of the AD program at Alcorn are basically like other AD programs throughout the nation; however, implementation in a rural setting is different. There is a common core of nursing knowledge that is basic to the AD level of preparation. Practice behaviors beyond the scope of competencies outlined for the AD graduate are the domain of the baccalaureate graduate. The Mississippi Council of Deans and Directors is validating the competencies of the levels of registered nursing in Mississippi and, in collaboration with the Society of Nursing Service Administration, hopes to demonstrate that competencies espoused will survive the tests of the practice arena.

In Mississippi, the "gap" between education and service is bridged by "before" and "after" actions based on mutual concerns of educators and service personnel. A summer externship program for students is sponsored by the Council of Deans and Directors and the Society of Nursing Service Administrators at selected agencies--between the freshman and sophomore years for AD students and between the junior and senior years in baccalaureate programs. Orientation programs ease role transition in the work place for the new graduates of all programs. Pierce acknowledged one of the pertinent issues before the profession of nursing--entry into practice--and the impact of this issue on the practice of nursing. She urged vigilance in monitoring the nurse practice acts, especially in states with Sunset laws.

EXPECTATIONS OF AD GRADUATES: AN EDUCATOR'S PERSPECTIVE

Sarah L. Etkin, Associate Professor, Department of Nursing, J. Sargeant Reynolds Community College (Richmond, Virginia), used the competency statements and premises of the National League for Nursing to describe the expected characteristics of AD nursing practice.

The performance expectations of the associate degree graduate at J. Sargeant Reynolds Community College are similar to those of other AD educators and are derived from the Montag model. Montag developed and implemented the role model for AD nursing which was intended to complement and be interdependent with the roles of the baccalaureate nurse. Faculty subscribe to premises underlining this model of practice:

1. Associate degree and baccalaureate degree nursing functions can be differentiated.

2. Nursing functions vary on a continuum ranging from a level using minimal to extremely complex levels of knowledge, skills, and judgment abilities. Most nursing activities utilize moderate levels of each. Since AD graduates practice from minimal to moderate range and baccalaureate graduates begin at the moderate range, there will be a frequent overlap of their activities.

3. Different levels of health care exist, and differently prepared nurses are needed for these levels. The associate degree nurse provides care at the secondary care level.

4. AD education will take place in institutions of higher learning which place emphasis on educational preparation rather than on service to an agency, and the program can be completed in two years of study and clinical experience.

The set of graduate competencies and premises developed by the National League for Nursing provides a basis for characteristics of the associate degree graduate. The graduate provides care to individual clients in a setting or agency that has a secondary health care focus and available supervision (either direct or indirect) from expert nurses. This graduate performs activities that require no more than moderately complex levels of nursing knowledge, skills, and judgment, and provides direct care to small groups of clients.

The performance expectations at J. Sargeant Reynolds include: a comprehensive content knowledge in each of the traditional specialties--medical, surgical, pediatrics, maternal-child, and psychiatric nursing; ability to apply theory to practice; and skill competency. The graduate is expected to be competent in specific skills designated as critical either because of the degree of difficulty, importance to practice, or having a narrow safety range if performed improperly. The faculty evaluates these skills in clinical or laboratory settings. (Chart 1 contains a list of the critical skills.)

CHART 1

Critical Skills

Aseptic technique
Catheterization
Charting
Care of chest tubes
Colostomy care
Intravenous therapy
Blood administration
Hyperalimentation
Medication administration
Nasogastric tube: patient care management
Oxygen therapy management
Pre- and post-operative care management
Suctioning
Tracheostomy patient care management
Vital signs (use of doppler, fetal heart sounds)

In addition to role competencies, critical skills, dosage calculations, and knowledge, the graduate is expected to make appropriate judgments and to use the knowledge to determine limitations that necessitate consultation with an experienced nurse.

Practice can be implemented best with staffing patterns that permit the AD graduate to give direct care to small groups of patients in the role of module leader rather than to direct a team in the role of manager of staff. If the number of stressors can be manipulated to facilitate the new graduates' transition, an optimum role adjustment will occur. Some of the stressors that contribute to the transition shock include staff rotation, unit rotation, staff attitude about teaching the new graduate, and insufficient individualized orientation. The demands of the work place, in many instances, impose constraints on the manipulation of stressors, e.g., shortages of registered nurses in some geographic settings. However, declining hospital census in the Virginia area will influence the need for various levels of workers. Hence, education and service personnel need to cooperate in planning for the future delivery of health care.

BRIDGES TO SUCCESS

Ann Larowe, Professor and Chairperson, Department of Nursing, University of Arkansas at Little Rock, also examined the parameters and philosophy of AD education. Excerpts from her paper—*Bridges to Success: Parameters and Philosophy of AD Education*—follow.

Misconceptions about associate degree nursing abound in our society, even though it is now 32 years since the first student graduated. Employers of nurses prepared in associate degree programs have not always been clear about the preparation of these graduates, which has led to confusion and inappropriate assignments. The resulting discrepancies have been difficult, but the areas of cooperation between nursing service and nursing education far exceed the discrepancy areas.

How best to prepare the associate degree nurse has been an issue since the first program strayed from the original descriptions provided by Mildred Montag in her 1951 publication, The Education of Nursing Technicians. In the foreword to that book, R. Louise McManus noted a dilemma that existed in 1951 and is still with us: "The dilemma of nursing education is to interpret accurately the impending changes in social need and corresponding changes in nursing functions, to study carefully the newest pertinent educational trends and principles, to plan wisely the needed adjustments in nursing education, and finally to institute courageously and experimentally the reconstructed program."

The belief underlying associate degree programs was that a registered nurse could be prepared in a two-year period to give quality care to most of the patients seeking care in the hospitals. That belief continues strongly within the AD community. Other

beliefs were, and are, that students learn vicariously through the pre- and post-conferences; the curriculum should include liberal arts, sciences, and nursing; and the program is based in a college setting.

One of the ways to understand modern AD nursing is to look at the parameters and philosophy which serve as the basis for this type of practice. Webster defines parameter as "a quality or constant whose value varies with the circumstances of its application." The parameters of practice can be reviewed best by using the list of Assumptions Basic to The Scope of Practice from Competencies of the Associate Degree Nurse on Entry into Practice, developed by the Council of Associate Degree Programs, National League for Nursing, in 1978. This document is useful because of the great input from educators and nursing service members. The assumptions basic to the scope of practice of the graduate of an associate degree program can be grouped into four categories: the type clients, the nursing abilities of the AD nurse, the supervision the graduate should receive and give, and the setting in which the nurse should practice.

Type of Clients

The oldest and most often quoted statement about clients for whom the AD nurse should care is that the clients should have common, well-defined health problems. This commitment has remained constant since the inception of associate degree programs in 1951. Montag noted that the great bulk of nursing functions were in the middle of a range from highly skilled and complex to those which were simple, routine, and required relatively little skill. She observed that most patients needed care in the middle of this range and that care could best be provided by the technically prepared nurse.

It is important to remember that the shortage of registered nurses (RNs) was extremely acute in the 1950s; the bulk of nursing care was given by aides trained during World War II. Assignment was highly functional. There were some licensed practical nurses; the number was increasing. Superimposed on this scene was the introduction of team nursing which was expected to put the RN back in charge of patient care. Team nursing called for use of a variety of nursing care workers who would complement each other. The introduction of the nursing technician at this time would provide an RN who would give direct patient care to most of the patients in the hospitals. This RN would work in cooperation with a professional nurse (Montag, 1951).

This commitment to the client whose needs fall in the middle range has remained constant throughout the 30-plus years of ADN history. The SREB Nursing Curriculum Project in 1976 recognized the need for a variety of workers and accepted secondary care as appropriate for clients who have illnesses that are common and well-defined, or who are in need of diagnostic evaluation or routine monitoring. In the SREB project, the RN would provide secondary care and would have associate degree or diploma preparation.

The type client for whom the AD nurse should care is further defined in the assumption statements. Additionally, the client may be one who needs medical diagnostic evaluation and has an acute or chronic illness. This fits well within the above statement of common, well-defined health problems.

The AD nurse is expected to be concerned with the individual client, but must give care with consideration of the person's relationship within a family, group, and community. Further, the nurse is to care for clients who need information or support to maintain health (NLN, 1978). While Montag's conception of the nursing technician did not include a client teaching function, it was not long before programs were including that content. The AD nurse was at the bedside and being asked about what to do at home; the nurses were capable of transmitting this teaching, and there simply were not enough professional nurses to do the teaching.

Ruth Matheney, in 1967, delivered a historic paper stating that, "The functions of the technical nurse include supporting nursing personnel and family in helping the patient to do for himself that which he can; for the technical nurse this means listening, suggesting, and informal teaching with nursing personnel and patient families and referral to other members of the health team (such as the professional nurse or physician) where indicated." A Western Interstate Commission for Higher Education (WICHE) pamphlet, The Graduate of Associate Degree Nursing Programs: Who Is This Nurse? describes the AD nurse as one who "recognizes the individual's need for instruction related to health and takes action to provide the instruction." Thus, the teacher-communicator roles came into AD nursing, and are accepted with little question today.

Nursing Abilities

The second category involves the nursing practice of the new AD nurse. Practice includes formulation of a nursing diagnosis and use of nursing interventions selected from established nursing protocols where probable outcomes are predictable. Montag's description of the graduate's role as presented in 1951 was quite different. She proposed a graduate who "would assist in planning of nursing care for patients; give general nursing care with supervision; and assist in the evaluation of the nursing given. These functions require skill and some judgment for their execution but they are dependent to a considerable degree on habit formation."

It is evident that the original role was quite restricted and was truly one of assisting a professional nurse. Montag made many references to the cooperative relationship of team members. Had team nursing been carried forth as designed, the assisting role for the AD graduate might have been appropriate.

As more was learned about community college education and nursing education programs developed more useful and creative structures for learning, it became evident that these students were capable and eager to acquire a more independent role than that of an assistant. Further, as these programs became the primary

and sometimes only supply of RNs in a community, employers and graduates requested changes in the education. By 1967, Matheney spoke of the technical or semiprofessional nurse as diagnosing common, broad, recurring nursing problems presented by patients. She further spoke of the nurse using the problem-solving process in identifying, planning, implementing, evaluating, and revising nursing care plans. This was not the assisting role as proposed in 1951.

Today, the nursing process forms the basis for teaching and delivering nurse care in almost all AD programs. Nursing diagnosis is a vital part of that process. As hospitals add this component to care plans, the new graduate must be able to use nursing diagnosis. This will help to unite diagnosis and related protocols of care, an area in which the AD nurse should excel.

Lack of skilled performance is one of the long-standing negative criticisms that nursing service personnel have about AD nurses as well as other new graduates. What does skilled mean? Robert Travers (1972) defines skilled performance as, "Repetititve behavior in which a complex sequence of actions is carried out in a more or less fixed way. The performance is automatic and smooth. Early performance involves step at a time actions with thinking intervening. So does performance that has not been practiced in the immediate past. The performer in both situations looks clumsy." AD nurse educators believe that new graduates deserve an orientation to the institution in which they will work. This orientation includes policies, philosophy, forms, and unique procedures. It is characterized by a willingness to supervise the graduates in procedures in which they have little or no experience; orientation does not mean giving a mini-AD program.

Supervision

The third category relates to supervision. Although Montag does not mention a supervisory role for the nursing technician, the WICHE statement of 1968 does make provision for the AD nurse to direct and guide other team members with less education and experience. However, the document specifically states, "This practitioner is not prepared through the education program to assume administrative responsibilities." Matheney's paper includes supervising other workers in the technical aspects of care. The ANA Position Paper of 1965 notes that "technical nursing practice involves working with professional nurse practitioners and others in planning the day-to-day care of patients. It (technical nursing practice) is supervising other workers in the technical aspects of care." That document further stated, "Technical nursing practice is unlimited in depth but limited in scope. Its complexity and extent are tremendous. It must be rendered under the direction of professional nurse practitioners."

What led to the addition of a supervising function that was so different from the original Montag belief? The greatest factor was lack of professional nurses in hospitals to provide the leadership and supervision. Rural hospitals had one supply of RNs--the new AD graduates, who soon found themselves in charge. Programs began to include a management component in the curriculum out of guilt as much as anything. Faculties said, "How can we throw the graduates into these situations without some preparation?

Another factor leading to inclusion of a management component was the rapid growth of associate degree nursing programs between 1967 and 1973. As a result of little orientation, some faculty members joined programs without accepting AD philosophy; they believed that AD nursing was really professional nursing, thus confusing the issue further.

The area of supervision caused as much difficulty in adopting the Council of Associate Degree competency document as the terms patient or client. Many persons would like to have specified that this graduate was guided by a professional nurse; however, recognition was given to the fact that this was not reality in many institutions. The accepted statement was that the nurse is guided by a more experienced registered nurse. The role of manager for the AD nurse, much more complex in the first draft, was revised based on input from educators throughout the nation.

Setting

The fourth category is the setting. The AD nurse's practice "may be in any structured care setting but primarily occurs within acute- and extended-care facilities" (NLN 1978). Montag (1951) expected the nurse technician "to give general nursing care with supervision." The obvious setting for this supervision was the hospitals; the curriculum was oriented to that setting.

New graduates of AD programs continue to seek the hospital setting as the primary location to begin practice--the NLN Career-Pattern Study notes that one year after graduation, 87 percent are employed in hospitals and 15 years later, 56 percent are in that setting. The statistics for AD and diploma graduates are very similar but baccalaureate graduates are down to 39 percent in hospitals after 15 years. The NLN study shows 48 percent of the AD nurses are staff nurses 15 years after graduation.

Where do we go in the immediate future? What changes will occur to necessitate revision of these basic assumptions about the practice of the AD nurse? There are so many unanswerable questions at this time that no one has a very clear crystal ball. Technological advances in equipment, the cure for cancer, decreasing hospital admissions and days of stay, Diagnostic Related Groups, Health Maintenance Organizations, and changes in the nurse education system will have an impact on all areas of nursing. Inevitably, care for the elderly, either in their homes or institutions, will demand more nurse hours than we presently devote to that population, and we will find nurses in other out-of-hospital care centers. The need for nurse educators and nursing service staffs to communicate and share their needs has never been greater. The Kellogg project to further cooperation between these groups could not have been more timely; the results of the efforts are eagerly awaited. Havinghurst's statement is pertinent. "Living is learning, and growing is learning--the human individual learns his way through life."

A COMPETENCY-BASED CURRICULUM: PROCESS AT KENNESAW COLLEGE

Ann Crutchfield and Vanice W. Roberts, Assistant Professors of Nursing, Kennesaw College (Marietta, Georgia), described the process of competency development in the AD program at Kennesaw.

The nursing faculty at Kennesaw College initiated major curriculum revisions in the fall of 1980. The faculty recognized the need to specify the roles or function of the AD graduates. The curriculum steering committee prepared and submitted the following questions to faculty: (1) What is the nature/definition of nursing--not just nursing process, but goals, purpose, function? (2) How would you classify the roles/functions of the nurse? Which do you see belonging to BSN? ADN? (3) How do you describe the recipient of nursing care? (4) How do you define health? Illness? (5) How do you see nursing fitting into your definition of health? Illness?

The responses indicated one of the problems with the curriculum was that of language. The committee compiled a list of 65 different terms/concepts used to answer the five questions. For example, several terms were applied to more than one concept.

The data also affirmed the need for clearly defined competency statements. Following lengthy curriculum committee meetings, the faculty achieved consensus regarding beliefs about nursing, its focus, and the scope of associate and baccalaureate degree nursing. The faculty wanted to make the curriculum more nursing oriented, for example, what the nurse will do for a client with a specified problem, rather than a disease process. The disease process would be discussed as an interference with need satisfaction. The emphasis would be on the activities of a nurse to assist the client in resolving the problem that results from the interference. The discussions confirmed the need to state those expected behaviors as evidence of whether the student had developed the abilities necessary to function effectively in the roles described in the program.

The faculty were in agreement with the competencies stated by the Associate Degree Council of the National League for Nursing. Therefore, the five roles of the AD nurse in the NLN competency statements became the framework for stating the abilities expected of the ADN graduate of Kennesaw College. The overlapping of roles, e.g., abilities as a communicator in other roles--provider of care, teacher, manager of client care--was acknowledged, but not viewed as a major deterrent. The stated competencies influenced the development of all nursing courses. The role of communicator illustrates how the development progressed.

The role of communicator is introduced in the philosophy and is maintained in the overall course objectives, overall clinical course objectives, and the unit clinical objectives. This role is introduced in the first nursing course and culminates in the terminal competencies. It appears in the philosophy statement "the faculty subscribes to the role as communicator," and in the third program objective which relates to

the expectation of the student upon completion of the program in nursing. The expectation is that the graduates will use therapeutic verbal and nonverbal communication techniques with clients, families, and health team members.

The program objectives provide the direction for the development of the six course objectives related to communication; the last course (Nursing 223), has the same communication objective as the program objective. The courses preceding Nursing 223 prepare students for the final role expectation as communicator.

The course objectives related to communicator are:

Nursing 121 - Practice communication techniques through interviewing, reporting, and recording.

Nursing 122 - Differentiate therapeutic from nontherapeutic communication while interacting with clients and health team members.

Nursing 123 - Evaluate therapeutic and nontherapeutic communication while interacting with clients, families, and nursing team members.

Nursing 221 - Demonstrate knowledge of the therapeutic communication appropriate for clients with alterations of thought processes.

Nursing 222 - Analyze previously learned communication techniques to establish and maintain therapeutic communication with clients, their families, and health team members.

Nursing 223 - Utilize therapeutic verbal and nonverbal communication techniques with clients, families, and health team members.

Due to the mechanics of rotating the numbers of nursing students into the clinical specialty areas, Nursing 221 and Nursing 222 are not required to be taken in numerical sequence, therefore, the objectives do not demonstrate an increase in complexity but a change in the emphasis on the type of client to whom communication is directed. In Nursing 221, the emphasis is on mental health clients; in Nursing 222, the emphasis is on family-centered nursing dealing with clients, such as the neonate, new mother, children, and parents of ill children.

The faculty's philosophical statement regarding learning is that learning has taken place when a change in behavior is evidenced. The ultimate change in behavior is stated as the terminal competency. These competencies are conceptualized as specific behaviors on the part of the student which indicate learning has taken place and also that the program objectives have been met. Furthermore, subunits of these behaviors were developed as clinical objectives for each course and are viewed as specific behaviors on the part of a student which indicate course objectives have been achieved.

The overall clinical objectives are identified clearly for each course indicating the acceptable behavior as communicator. Examples from each course related to the role of communicator are:

Nursing 121- 1. Practice the role of communicator by using interviewing, reporting, recording techniques.

2. Utilize beginning skills of reporting on and off within the clinical setting.

3. Apply communication skills in collecting a data base and planning nursing care.

4. Apply written and spoken communication skills in recording assessments and formulating a nursing care plan.

5. Evaluate effectiveness of one's own interviewing techniques.

Nursing 122 - 1. Identify verbal and nonverbal communications of clients, based on knowledge and technique of interpersonal communication.

2. Utilize beginning skills of reporting within the clinical setting.

3. Apply communication skills in collecting a data base and planning nursing care.

4. Apply written and spoken communication skills and begin to record assessment, nursing care plans, and nursing interventions.

5. Identify therapeutic communication with one client and nursing team members.

6. Recognize the need for client referral to other health sources.

7. Interpret own feelings when communicating with a client.

Nursing 123 - 1. Identify verbal and nonverbal communication of clients and families, based upon knowledge and techniques of interpersonal communication.

2. Utilize acquired knowledge of reporting on and off within the clinical setting.

3. Demonstrate communication skills in assessing, planning, implementing, and evaluating nursing care.

4. Communicate and record assessments, nursing care plans, interventions, and evaluations accurately and promptly.

5. Demonstrate skills in maintaining therapeutic communication with client, family, and nursing team members.

6. Initiate client referral by communication with nursing team members.

7. Examine the effectiveness of one's own communication with clients, colleagues, and others.

Nursing 221 - 1. Using acquired knowledge, interpret verbal and nonverbal communications of client and family, based upon knowledge and techniques of interpersonal communication.

2. Establish effective lines of communication with other health team members.

3. Apply previously learned communication skills as a method of data collection, planning, implementation, and evaluation of nursing care.

4. Apply previously acquired knowledge to communicate and record assessment, planning, implementation, and evaluation accurately and promptly.

5. Practice therapeutic communication with clients and families.

6. Demonstrate knowledge of beginning communication skills through the appropriate use of referral.

7. Analyze the effectiveness of one's own communication with clients, colleagues, and others.

Nursing 222 - 1. Interpret verbal and nonverbal communication of clients and families, based upon acquired knowledge of interpersonal communication.

2. Establish effective lines of communication with other health team members.

3. Apply previously learned communication skills as a method of data collection, planning, implementation, and evaluation of nursing care.

4. Communicate and record assessments, nursing care plan, interventions, and evaluation accurately and promptly.

5. Practice therapeutic communication with clients, families, and health team members.

6. Demonstrate communication skills through the appropriate use of referral.

7. Analyze the effectiveness of one's own communication with clients, colleagues, and others.

Nursing 223 - 1. Assess verbal and nonverbal communication of clients and family, based upon knowledge and techniques of interpersonal communication.

2. Employ lines of authority and communication within the clinical setting.

3. Employ communication skills as a method of data collection, nursing intervention, and evaluation of care.

4. Communicate and record assessments, nursing care plans, interventions, and evaluations accurately and promptly.

5. Establish and maintain therapeutic communication with clients, families, and health team members.

6. Communicate client's needs through the appropriate use of referral to other health resources.

7. Evaluate the effectiveness of one's own communication with clients, colleagues, and others.

The overall clinical objectives for communicator in Nursing 223 are the behaviors the faculty feels are necessary to perform as a competent associate degree nurse. Therefore, the Nursing 223 overall clinical objectives are also the program's terminal competency for communicator.

The unit clinical objectives are another more specific step which delineates the type of experience that may be required to achieve the course clinical objectives. Examples of unit clinical objectives for Nursing 121 follow:

Nursing 121 - 1. Initiate a nurse/client interview and interaction (Unit III).

2. Report and record variations in vital signs (Unit IV).

3. Report variations in vital signs which require interventions (Unit V).

Examples of unit clinical objectives for Nursing 122 in which the nursing student is expected to broaden the area and ability to function follow:

Nursing 122 - 1. Initiate a client/nurse interview and interaction utilizing therapeutic communication skills (Unit I).

2. Use principles of communication to facilitate care of clients experiencing alteration in sensory perception (Unit III).

3. Use principles of communication to facilitate care of a client and family experiencing an alteration in level of consciousness (Unit III).

4. Use principles of communication in implementing a teaching plan for clients of various ages (Unit IV).

5. Identify own level of anxiety being communicated during client interaction (Univ IV).

6. Relate modifications in communication skills necessary to be effective in dealing with levels of anxiety.

Although the role of communicator was defined, the faculty discovered the student had difficulty knowing what needed to be done to meet the stated objectives. Nursing 121 had developed guidelines to assist the new nursing student in her day-to-day, minute-to-minute activities. The faculty recognized that knowing what activity would enable meeting objectives was most helpful to the student. Thus, the clinical objectives guide was developed. The guide was organized according to the structure of the cognate material, with the units arranged by the five interrelated roles of the nurse--provider of care, communicator, teacher, manager, and professional.

The activities and objectives included only new behaviors related to that unit and the role. An inclusive statement at the beginning of the guide explains that students are to build on prior knowledge. Unit III, Assisting Man to Identify His Problems (Nursing 121), is a good example of how the clinical objective guide was organized. The communicator role objective is "Initiate a nurse/client interview and interaction." The activity which enables the student to meet the objective is for an assigned client contact, interview, and identification of needs. The activity informs the student clearly on how to meet the objective.

Competency-based education has improved the cohesiveness of the program of nursing. The faculty are using the same langugage and are working toward the same goals. There is no longer the problem of not knowing what another course included, duplicating material, or omitting it altogether. However, work continues on the objectives, making them understandable and improving the flow from course objectives to clinical course objectives to unit clinical objectives to the clinical guides. The process never stops.

PERFORMANCE DIFFERENCES IN GRADUATES OF ASSOCIATE AND BACCALAUREATE DEGREE PROGRAMS

Four Assistant Professors of Nursing at Kennesaw College (Marietta, Georgia)—Annette Bairan, Leslie Brown, Pamela Chally, and Beverly Farnsworth—replicated a study done by Gray (1977) at the University of Vermont to demonstrate differences in performance of graduates from associate degree and baccalaureate programs.

"Nurses seem to have an almost compelling, driving need to deny differentiation. We're all the same. No one is different. No matter how we are prepared, we all take the same licensing examination and write the same initials after our names . . . . This deification of sameness has almost destroyed nursing . . ." (Smoyak, 1976).

Denial of differentiation extends to many employing agencies, where little attention is paid to type of preparation, and to the general public, where the attitude of "a nurse is a nurse is a nurse" is commonly reflected. Montag proposed that technical nurses be prepared in community colleges. Her proposal was based on two premises: 1) "that functions of nursing can and should be differentiated, and 2) that these functions lie along a continuum with professional at one end and technical at the other . . . ."

Historically, the differences between technical and professional nursing have become of increasing interest since the ANA position paper of 1965. Chater (1969) suggested that the technical nurse's focus of care be on the individual patient, while the focus of the baccalaureate nurse be expanded to include groups of patients. Matheney (1974) described technical nursing as "the direct nursing care of patients with evident health problems and common recurring nursing problems in the areas of physical comfort and safety, physiological malfunction, psychological and social problems, and rehabilitation problems. . . . Technical nursing practice involves coordination of functions with other health services and the provision of quality nursing care under the leadership of a professional nurse."

The Nursing Curriculum Project (NCP), administered by the Southern Regional Education Board, defined the differences between the beginning generalist programs--associate degree and baccalaureate—in terms of the competencies of their graduates and the general body of nursing knowledge that should be taught in each program (SREB, 1976). In sum, two types of programs were defined: "The AD program prepares the graduate to function as first-level staff nurse in secondary care, i.e., as a generalist attending to illnesses that are common, recurrent, and relatively predictable. The baccalaureate program also prepares for secondary care, but in addition, for beginning positions in primary care, i.e., health monitoring and disease prevention, usually in non-hospital settings, and should also provide the graduate with an optional area of concentration."

A delineation of the competencies of various nursing graduates by a National League for Nursing task force in 1979 identified differences in terms of knowledge, practice, and expected competencies. These differences were related to the increased comprehensiveness of care and the use of nursing theory, change theory, and research findings by baccalaureate degree graduates.

Various studies describe actual practice differences between associate degree and baccalaureate degree graduates. Waters et al. (1972) described differences between graduates of associate and baccalaureate degree programs in 12 selected San Francisco Bay Area hospitals. The actions and attitudes of AD graduates were consistent with technical nursing practice; baccalaureate graduates practiced professional nursing. Gray et al. (1977) explored the differences in specific nursing care situations in a sample of 44 graduating seniors from associate degreee and baccalaureate nursing programs. Differences occurred in the "areas of technical skills, teaching, leadership, giving support to the patient and family, interviewing for assessment purposes, actions in structured situations and actions following observation."

Chamings and Teevan (1979) sampled baccalaureate and associate degree programs across the United States to detect differences in expectations and competencies. The authors reported the evidence as inconclusive in determining whether graduates of baccalaureate degree and associate degree programs actually function differently, but a pattern seems to indicate that associate degree programs stress more technically oriented skills, and that baccalaureate degree programs emphasize theoretical concepts and problem solving. In a replication of a study conducted at the University of Vermont, Sharrad (1983) determined that associate degree and baccalaureate degree graduates at Indiana State University did list nursing activities appropriate for their respective levels of practice. The responses of the baccalaureate degree graduates were significantly different than those of the associate degree graduates "in leadership, emotionally supportive actions, nursing process, and use of extra time."

In the study at the University of Vermont, Gray (1977) hypothesized "measurable differences in the performance of graduates of technical and professional nursing programs in the areas of: 1) technical skills, 2) teaching, 3) leadership, 4) giving support to the patient and family, 5) interviewing for assessment purposes, 6) actions in structured situations, and 7) actions following observation."

Additional hypotheses considered in the replication at Kennesaw College were: (1) associate degree graduates will score higher in the technical category than will baccalaureate graduates; (2) baccalaureate graduates will score higher in the professional category than will associate degree graduates and (3) associate degree and baccalaureate graduates will score the same in the "all-nurse" category.

The sample for the Kennesaw study consisted of twenty 1983 graduates--ten associate degree and ten baccalaureate. The associate degree graduates were from Kennesaw College; the baccalaureate graduates represented five different baccalaureate programs in Georgia. The Gray instrument--six clinical situations expressed in open-ended essay type questions--was used to collect the information. The questionnaire was self-administered and graded jointly by four associate degree nursing educators, using the key developed by Gray. Responses were classified as either "all-nurse"

(actions expected of both associate degree and baccalaureate graduates). Technical (actions expected of associate degree graduates only), or professional (actions expected of baccalaureate graduates only). One point was assigned for each category of action.

Table 1 provides information about the sample characteristics. A majority (60 percent) of both groups was unmarried. A slightly higher percentage of the baccalaureate graduates than associate degree graduates scored under 1000 on the Scholastic Aptitude Test (SAT). In contrast, the baccalaureate graduates reported higher college grade-point averages. The associate degree graduates were slightly older than the baccalaureate graduates. The average age of the associate degree graduate was 26; that of the baccalaureate graduate was 23.

TABLE 1

Characteristics of Graduates in Kennesaw College Sample

Characteristics	Graduates	
	Associate Degree (N=10)	Baccalaureate Degree (N=10)
Married	40%	40%
SAT Scores*		
Over 1000	10	10
Under 1000	50	60
High School Grade Rank*		
91 - 100	10	40
76 - 90	30	40
51 - 75	40	10
College Grade-Point Average		
3.50 - 4.00	—	10
3.00 - 3.49	40	60
2.50 - 2.99	40	30
2.00 - 2.49	20	—

* Some graduates did not respond.

Table 2 contains the mean scores for the graduates by the three broad categories of professional, technical, all-nurse, and also the total scores. Higher scores were received by the baccalaureate graduates on all except the all-nurse category. Of the four categories, the professional category was the only one in which the difference between the two means was statistically significant. This category difference was also significant in the Gray study. (In the Gray study, the group differences were also significant for the technical and total score categories, with the baccalaureate group scoring higher in the professional and total categories, and the associate degree group scoring higher in the technical category.)

Although the difference was negligible, the associate degree graduates scored slightly lower than the baccalaureate graduates in technical category. This was unexpected.

TABLE 2

Mean Scores of Kennesaw Sample

	Mean Scores of Graduates		
Categories	Associate (N=10)	Baccalaureate (N=10)	Significance
Professional Points	12.0	8.7	*
Technical Points	1.5	1.4	N.S.
All-Nurse Points	38.0	39.4	N.S.
Total Score	51.5	49.5	N.S.

* Significant at $p < .05$
df = 18
N.S. = not significant

The reported differences in responses between the associate degree and baccalaureate degree graduates in this study lend validity to the theoretical definition of nursing. These differences have implications for nursing education and nursing service. Nursing educators can analyze the types of student learning experiences in terms of the technical, professional, and all nurse functions. From this, they can use the combination of experiences associated with the associate or baccalaureate degree nursing definition. Periodic evaluation of their graduates in terms of nursing competencies may necessitate changes in educational expectations, such as increasing or decreasing the level and the scope in order to achieve educational goals. Nursing service can use the educational preparation and level of competency of graduates in staffing decisions. Agencies can discriminate between management and leadership functions, and try to use the baccalaureate degree graduate for leadership functions and the associate degree graduate for management functions (Gray et al., 1977).

PROPOSED SOLUTIONS TO ISSUES IN ASSOCIATE DEGREE NURSING

Zeila W. Bailey, Vice President, Nursing Administration, Baptist Medical Center-Montclair (Birmingham, Alabama) and Dorothy Scott, Assistant Professor of Nursing, Samford University (Birmingham, Alabama) agreed with the remarks of Sylvia Hart (Allen and Hoddick, 1983) who stated, ". . . there is no doubt that the development of associate degree nursing programs was a move in the right direction for nursing."

Associate degree education has some distinct advantages in nursing education. It pushed nursing education into the mainstream of higher education. The subsequent changes in the admission requirements permit entry of people to nursing programs who otherwise would have been prohibited because of age, sex, or marital status. The two most outstanding complaints are that the AD graduates (1) do not have the technical skills needed to function and (2) that AD graduates are not prepared for leadership positions (Allen and Hoddick, 1983).

A survey of nursing educators and nursing service managers at Samford University and Baptist Medical Center-Montclair was conducted to determine perceptions of AD competencies. The ANA Commission on Nursing Education Selected Nurse Competencies: Role and Function (1980) was used to design a questionnaire. The categories used were : (1) Role and Function as Provider of Client Care, (2) Provider of Care, (3) Client Teacher, (4) Planner and Coordinator of Client Care, (5) Communicator, (6) investigator, and (7) Discipline of Nursing. Within each category, several questions were asked to determine perceptions of nursing managers and nursing educators about specific competencies.

Participants were asked to use a scale and evaluate their perception of "how it is" and also their perception of "how it should be." The scale for the evaluation of competencies is as follows:

1 = has potential ability and scientific principles and concepts to meet the competency, but lacks adequate clinical experience to perform without supervision.

2 = has knowledge and clinical experience so that he/she is expected to perform without supervision; however, proficiency is not yet attained.

3 = has multiple opportunities to practice the competency and perform the competency without supervision.

In addition to the AD competencies, 18 competencies from the expectations of baccalaureate degree graduates from the same source were included. This was done in order to determine whether managers and faculty could differentiate expected competencies of AD and BSN graduates. Twenty-six educators from the Ida. V. Moffett School of Nursing and faculty nursing managers at Baptist Medical Center-Montclair and Baptist Medical Center-Princeton participated in the survey. The results were:

1. There is no significant difference in the perceptions of faculty and managers regarding competencies AD graduates have or should have. Multiple t-tests were performed to determine whether or not there were significant differences between perceptions of the AD nurses' present competencies and what they should be. No significant differences were found. This was true for all respondents as well as for educators alone and practitioners alone. Faculty and managers agree that AD competencies are as they should be.

2. There is a significant difference between educators and managers on one dimension--the perception of how the AD nurse ought to perform the role of investigator ($p = .05$). Managers felt the AD nurse should exhibit greater competency in this role.

3. While a few faculty and managers marked certain competencies N/A, this number was insignificant. Most did not identify any competency listed in the survey to be inappropriate (not applicable) to the associate degree graduate. There was no significant difference in these scores between faculty and managers.

The results of the survey were very perplexing. Why did the disparity between philosophies of service and education not show up on the survey? Speculations include:

Blend of expectations and philosophies. The school and the hospitals are closely associated. Graduates of the nursing program are used in the institutions, and there is a great deal of dialogue both formally and informally between service and education.

Orientation. The competencies are not clearly recognized because of the well-designed orientation programs which identify and meet individual needs of new graduates.

Differentation in workplace. Two levels of practice are not recognized or encouraged at the hospitals. The hospital staffs, including the nursing administrators, have not recognized the difference in AD and BSN competencies. While lip service has been given to educational preparation through encouraging employees to continue their education, once they have accomplished that goal, they are used by the system no differently than they had been previously--nor are there different expectations for the nurse with the BSN degree. The job description is the same, but they do receive a four percent increase in pay. What a waste of education, and what a waste of money!

Awareness. The faculty and managers who participated in the survey did not recognize competencies beyond the scope of beginning AD practice.

The philosophy of AD education is not understood by all associate degree faculty members. Graduate programs have, for the most part, ignored associate degree education in the preparation of faculty. The result has been faculty with little understanding of the AD philosophy and the faculty role, e.g., curriculum development and teaching skills. All of these deficiencies affect the AD nursing curriculum. Because the philosophy of AD education has been ignored, and because of the pressure from service to produce a "bionic nurse," AD faculty tend to teach "all they know" rather than the knowledge, concepts, and principles needed for technical nursing.

If nurses are willing to become the change agents who will face the issues and look for solutions, answers can be found to the problems. Proposed solutions in Alabama include:

Faculty Understanding of AD Philosophy. It is proposed that through the Council of Deans and Directors of Schools of Nursing, graduate programs in nursing revise their curricula to include objectives to teach the philosophy of associate degree education to potential faculty. Further, it is proposed that present faculty in associate degree nursing programs (and in the future, new faculty) receive definite and clear orientation to the philosophy and concepts of ADN education. This can be done easily through the development of a videotape which can be shared with all schools. It is suggested that funding for this project be sought via a grant.

Evaluating AD Curricular Design. Each dean/director of the AD program and appropriate faculty should evaluate the curriculum to determine if inappropriate content has crept into the program in an attempt to make the graduates "all things to all people." These discrepancies should be corrected at the earliest possible time. It is suggested that the Alabama Board of Nursing coordinate this activity.

Establishing Levels of Practice in Secondary Settings. Service must establish expectations for professional and technical nurses through career ladders or through other visible and tangible systems. Unless two levels of practice are established, the separate levels of education are unwarranted and unjustified. If technical and professional nursing is desired practice in institutions, it must be recognized, nurtured, and rewarded. There is already an active committee in Alabama working on career ladders for nurses. The work of this committee needs to be encouraged and facilitated so that we can have the benefit of their work in our respective institutions. Through the Alabama Society for Nursing Service Administrators, a task force should be formed to assure the success of this project.

Mutual Understanding of AD Educational Concepts. The Alabama Society for Nursing Service Administrators and the Council of Deans and Directors need to implement a massive educational effort in which the philosophy of ADN education is clarified and graduate school curricula changes are addressed that will reach 1,000 nurses in the state of Alabama within the next 12 months. This will require support of nursing administrators and deans and directors. There must be a ground swell, grass roots effort to educate nurses everywhere about the difference in technical and professional practice. This must include education and service from all levels of our colleges and universities and from all levels of nursing services. It will not suffice to touch just a few key people with this information. Nurses everywhere must understand the differences and must take action based on the information obtained. If everyone says, "Oh, that won't work for us," then nothing has been gained. To make this happen, the Alabama Board of Nursing needs to accept this as an objective for education of Alabama nurses during the fiscal year 1984-85.

Clarification of Licensing Exams. There should be two licensing examinations--one for technical practice, and one for professional practice. Graduates of diploma, AD, and baccalaureate programs would be required to write the technical examination. Additionally, baccalaureate graduates would be required to write an examination testing their competency for professional practice. A task force consisting of nursing service administrators, deans, and directors needs to be appointed to work with the Alabama Board of Nursing on this project.

Inadequate Research. Research is needed in the following areas to determine:

1. The impact of clinical ladder programs on the appropriate use of technical and professional nurses.

2. How orientation of faculty to concepts and principles of AD education affect curricula design and teaching plans.

3. How inclusion of AD philosophy in graduate programs of nursing affect faculty when they assume teaching positions.

The potential for generating research questions is limitless. Too long nurses have said, "If only they would take action." The profession of nursing is being damaged by a critical attitude, a selfish desire to perpetuate individual interests, and by a "let George do it" attitude.

EXPECTATIONS OF AD GRADUATES: A NURSING SERVICE DIRECTOR'S PERSPECTIVE

Although the skill levels of any graduate depend upon educational preparation, Jacqueline Mardan, Director of Nursing at Chippenham Hospital in Richmond, Virginia, believes the same thing is expected of all beginning graduates in the workplace.

The structure of orientation programs, Mardan asserts, is the same for all beginning graduates. At Chippenham Hospital, a five-week orientation is planned for the beginning graduates. The orientation program is divided between classroom and time with a preceptor on a designated unit. The classroom session provides opportunities for the new graduate to learn about policies and procedures of Chippenham Hospital; for example, medications, documentation, response in emergency situations. The new employee learns the operational procedures of the particular unit and practices various skills. A sample of a skills checklist used on medical/surgical units at Chippenham appears in Chart 2. This five-week period permits gradual assimilation of information, a period of adjustment to the environment, and gradual increase in responsibility. At the end of the orientation period, the new graduate is expected to practice nursing safely within the Chippenham Hospital environment.

Three words summarize Mardan's expectations of a beginning nurse: responsible, accountable, and professional. Graduates need to be relatively certain the work setting will meet their personal and professional criteria. Therefore, Mardan encourages beginning nurses to "shop around" before making a decision about a particular unit. Evidence of responsibility appears in the selection of the unit and the development of consistent work patterns. Accountability is evident in the type care provided and the establishment of trust among colleagues, including the director of nursing service. "Professional," according to Mardan, may be difficult to define but will be manifest in performance behaviors with clients, the family, and colleagues.

Standards of performance established at Chippenham Hospital help the graduates and nursing supervisors evaluate performance. Areas addressed include: use of the nursing process, application of policies and procedures of the Department of Nursing, decision-making ability, leadership ability, communication skills (written and oral), personal decorum (attitude, appearance, behavior), and professional growth and development (in-service and continuing education activities).

A sample of one standard appears in Chart 3. Each standard is rated on a scale of 5 to 1 (5 = outstanding, 1 = unsatisfactory). The employee and the supervisor review the evaluations, make recommendations, and set goals for continuing practice.

CHART 2

Skill Training Checklist At
Chippenham Hospital
Medical/Surgical Areas

Name _____ Unit _____ Date Received _____

The Following Skills Must Be Supervised by an RN on the Nursing Unit

I. Application Care and Charting of: Supervised By / Date

A. Urinary Drainage
   1. Clamping Foley catheter for bladder training
   2. Emptying, measuring Foley drainage
   3. Application of Texas special
   4. Application of leg bag
   5. Perineal care with Foley catheter
   6. Urinary catheterization

B. Traction
   1. Bucks
   2. Cervical
   3. Pelvic
   4. Crutchfield tongs

II. Special Procedures:

A. Tubes
   1. Emptying, measuring Hemovac
   2. Administration of tube feedings

B. Dressings
   1. Changing sterile dressing

C. Chest drainage
   1. Thermotic chest pump
   2. Pleur-Evac
   3. Emerson Pump

D. Tracheostomy
   1. Care of
   2. Suctioning

E. Colostomy
   1. Care of
   2. Irrigation of

III. For RNs Only:

A. N/G tube insertion
B. Suture, clip removal/charting
C. Shortening, removing, drains/charting
D. Use of heparin lock
E. Administration of IV medications
F. Blood administration
G. Skin test administration, interpretation
H. CVP lines
I. Conducting team conferences
J. Making team conferences
K. Change of shift report
L. Care plan development
M. Hyperalimentation
   1. Dressing change
   2. Bottle change

TO BE COMPLETED WITHIN THREE MONTHS. RETURN AFTER COMPLETION BY _____ Date

TO NURSING ADMINISTRATION. (To be filed in Personnel Folder)
HEAD NURSE MUST SIGN, INDICATING SATISFACTORY COMPLETION.

Date _____ Approved, Head Nurse _____ Date _____ Received, Nursing Administration _____

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CHART 3

Standards of Performance

I. Is instrumental in planning, implementing, and evaluating patient care based on the Nursing Process.

	1	2	3	4	5
A. Assesses and documents the patients' status upon admission.					
B. Develops a written care plan including goals and nursing actions.					
C. Implements the care plan and documents the patient's response on appropriate forms.					
D. Continuously re-evaluates patient's status and revises care plan accordingly.					
E. Encourages patient and family participation in the formulation and/or revision of the care plan.					
F. Documents discharge plans and explains plans to patient and family.					
TOTAL:					

COMMENTS: _____

_____

_____

THE REALITY OF THE WORKPLACE

According to Mona Raborn, Director of Nursing, Jefferson Davis Memorial Hospital (Natchez, Mississippi), AD graduates are used in many roles at Jefferson Davis Memorial—as staff nurses on general medical and surgical units, and on all specialty units; as coordinators of Infection Control, and In-service Education; as head nurses, and as supervisor. She realizes the graduates are not prepared for leadership roles (and knows that the graduates are aware of their limitations), however, the reality of the workplace mandates the use of these graduates in leadership positions.

In some rural hospitals, Raborn asserts, there may be no baccalaureate prepared nurses. Therefore, although she supports the promotion of the baccalaureate degree for such positions, she must recognize and cope with the realities in a 205-bed acute care hospital. (In February 1984, the staff mix was 99 AD, 20 diploma, 19 baccalaureate, and 2 master's prepared graduates. Of the 140 registered nurses, head nurse positions were held by 8 AD, 1 baccalaureate, 3 diploma, and 2 master's prepared graduates.)

Among the expectations of AD graduates at Jefferson Davis Memorial Hospital are maturity, commitment to nursing, a realistic view of nursing practice in hospitals (e.g., awareness of three shifts to cover seven days per week--365 days per year), awareness of limitations, basic nursing skill competency, and success on the licensing examination. All graduates are in the same orientation program, which is designed to assist the new graduate in the transition from the role of student to that of staff nurse. The orientation, conducted by the In-service Education Department, is currently a six-week program. (By June 1985, it will be extended to 12 weeks.) The program includes some classroom lectures, a review of policies and procedures, testing, skills checklist, the job description, and scheduled time on the clinical unit. Each graduate is assigned a preceptor throughout the orientation period.

Upon completion of the planned orientation program and certification as registered nurses, the AD graduates are expected to function appropriately as described in the staff nurse job description. They are expected to deliver individualized goal-directed nursing care to patients through the use of the nursing process--a provider of care, a communicator, a manager of patient care, a patient teacher, and a member of the nursing profession. Raborn observed that AD graduates are strong in theoretical background and documentation skills. She believes their skills in the roles of provider of care and patient care manager need to be strengthened.

At Jefferson Davis Memorial, AD graduates may be assigned to the specialty areas. Ideally, these assignments are made after one year's experience in the other areas. There are exceptions, due to the demands of the setting. Individual maturity, abilities, and career goals are factors used to determine readiness for specialty area assignments when the demands of the workplace must be given priority. ADN graduates assigned to work in specialty areas receive additional orientation and take an organized course appropriate to the area.

Raborn urged alertness to the financial environment of a hospital in addressing current issues facing the profession of nursing. More than ever, she argued, nursing must be prepared to represent its interest in budgetary and management meetings.

AN EDUCATIONAL CLINICAL PRECEPTORSHIP

Marianne Crouse, Staff Development Coordinator at Howard General Hospital (Columbia, Maryland) and Emily Slunt, Associate Professor of Nursing, Howard Community College (Columbia, Maryland) described the Intra-Program Clinical Preceptorship during a workshop held at Howard Community College; Brenda Carter, Associate Professor of Nursing, Howard Community College, discussed this preceptorship program at a regional conference.

A gap exists between the idealistic approach to nursing found in the school curriculum and the real world expectations of nursing service. This problem, identified by both nursing educators and nursing service personnel, became increasingly pronounced as nursing education moved from a hospital-based orientation to one based in an educational setting. Attempting to bridge the gap creates anxiety and conflict within the new graduate. The preceptorship program represents a cooperative effort to alleviate the effects of the problem.

The preceptor program at Howard Community College was established in January 1980, during a minimester session. It was offered as a credit free course the first year; however, it has become a two- or three-credit elective course offered during the month of January. Students who have completed three of the four semesters in the nursing program are eligible to participate.

The focus of the course is the student. The major goals are increased learning, efficiency, and self-confidence. These goals reflect a change in behavior in each of the domains: cognitive, psychomotor, and affective. The course allows for individual differences and recognizes the ability of the adult learner to assess needs. The following options reflect the flexibility of the preceptor program:

1) The student may register for two or three clinical credits. The two-credit option may consist of two clinical credits or one clinical and one theory; the three-credit option consists of two clinical credits and one theory credit.

2) Students sign up for clinical days, evenings, or nights to match a preceptor's schedule. The 11 required shifts may be completed consecutively or spread throughout the month.

3) There is a choice of hospital units based on student interest.

4) Students may choose to match schedules with one or more preceptors.

5) Students are advised that they may audit the course. An audit status requires attendance at all sessions, but exempts the student from written assignments.

In 1983, 63 percent of the enrollment was for two credits of clinical and the other options were split equally. The percentage of students who elected the audit option was 82. The course could have been used to fulfill up to three of six credits allotted for electives in the curriculum. It appears that motivation for this course was based on perceived learning need rather than a need for credit.

Several elements are essential for the achievement of the goals of the preceptorship program. The role model serves to socialize the student to the behaviors of the staff nurse. The preceptor is someone functioning successfully in a particular role. Rotation among shifts exposes the student to the nursing responsibilities inherent in working evenings and nights. It also provides the opportunity to observe patient needs at different times of the day. Being in the clinical area for the full eight-hour shift is also a new experience. This exposure typifies the real world and lessens the disparity in role expectation and reality.

Student assignments are constructed by the preceptor who is ultimately responsible for patient care. Incorporating care of a group of patients enhances the student's efficiency of organization, priority setting, and skill experience. Decisions are made without dependence on the instructor so that self-confidence and a sense of accountability are improved.

Self-assessment helps students recognize learning needs and to increase strengths. Students develop their learning objectives with guidance from faculty. The achievement of these objectives is assessed on an ongoing basis. Self-assessment also includes value clarification.

Evaluation is summative. It is related to the individual's objectives and consolidates feedback from preceptors. A checklist with comments is used to record this feedback. A sample of the list appears in Chart 4. The course itself is evaluated to verify whether the goals of increased learning, efficiency, and self-confidence were met.

The roles of faculty, students, and preceptors differ from those assumed generally in clinical situations. Chart 5 provides information about the role expectations of faculty, student, and preceptor. The role of the faculty in the preceptorship program is primarily one of communicator. The faculty are the link between the student, preceptor, and objectives. This person explains the responsibilities of the participants and elaborates on student assets and limitations in terms of prior experiences. The faculty visit the clinical units to interact with the preceptors and students and are also available by phone whenever students are scheduled. The faculty evaluate the written assignments and the course. The preceptor evaluates the clinical performance.

CHART 4

Nursing 211

Howard Community College
Nursing Education Program
Feedback For Students

Intersession 1983

Student: _____

Preceptor: _____

Date: _____

	Satisfactory	Unsatisfactory	Comments
I. PERSONAL CHARACTERISTICS			
A. Responds accurately and honestly.			
B. Maintains privacy and professional confidentiality.			
C. Cooperates with members of team in achieving patient care and learning.			
D. Demonstrates dependability in work situations.			
E. Maintains professional attire and relationships.			
F. Functions in accord with legal constraints.			
II. COMMUNICATION TECHNIQUES			
A. Utilizes communication techniques and channels which are appropriate to the situation and directed toward meeting patient needs.			
B. Seeks supervision, direction, and clarification appropriately.			
C. Seeks learning experiences with degree of independence.			
D. Actively performs group roles as related to patient care.			
III. ORGANIZATION AND WORK SKILLS			
A. Plans activities before beginning.			
B. Carries out work with efficiency.			
C. Reports to appropriate people regarding problems and work status.			
D. Uses initiative in carrying out responsibilities.			
E. Works in a manner that addresses patient priorities.			
F. Cares for reasonable number of patients.			
IV. PROVISION FOR PATIENT SAFETY			
A. Makes appropriate and accurate observations.			
B. Records and/or reports patient status accurately and thoroughly within reasonable time.			
C. Identifies major patient needs.			
D. Arrives at safe judgments regarding patient needs and nursing actions.			
E. Nursing actions administered in manner which contributes to safety in the following areas:			
1. Physical			
2. Psychological			
3. Nutritional			
4. Pharmacological			
5. Rehabilitational			
F. Uses theory base to plan and administer patient care.			
G. Evaluates care realistically, and makes appropriate changes during and at completion of care.			
H. Seeks assistance when needed in planning or giving care.			

Additional Remarks:

Signature of Student _____

Signature of Preceptor _____

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CHART 5

Howard Community College
Nursing Education Program
Role Expectations

Faculty Member

1. Develop schedule for student placement and rotations.
2. Periodically contact students in the clinical setting.
3. Keep preceptors informed of rotations and general course events.
4. Meet with preceptors to handle problems and coordinate assessment of student progress.
5. Be available for contact in event of problems/questions.

Student

1. Prepare personal objectives for this experience.
2. Receive assignment from preceptor and--with guidance--plan, execute, and evaluate care.
3. Apply the nursing process concept with assigned patients.
4. Review and revise care plans with ongoing changes in the patient's condition.
5. Reinforce areas of strength and identify areas that need improvement.
6. Participate in activities unique to a specific nursing shift, as assigned by the preceptor.
7. Evaluate the total experience with the preceptor and instructor.

Preceptor

1. Provide opportunities for the practicum student to pursue individual learning objectives within the parameters of the overall course objectives and the agency protocol.
2. Provide opportunities for the practicum student to function in a team member role.
3. Serve as a resource person, consultant, and supervisor for the student's clinical experience.
4. Make student assignments, giving careful attention to the objectives of the practicum and the scope of the student's knowledge and skills.
5. Keep periodic anecdotal notes on the student's progress during the practicum.
6. Assist the faculty in evaluating the student's performance, based on clinical requirements.
7. Plan with the practicum student to reinforce areas of strengths and identify deficiencies.
8. Assist the faculty in evaluating the mini-practicum experience.

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The individualized objectives written by the students are the key to maintaining the focus on the learning needs of the student rather than the service needs of the hospital. The students write objectives, select assignments or learning experiences. The fact that students write their own objectives is significant. They are very involved in the planning of their experiences.

The type of experience needed to achieve the specific objectives of the student was identified and discussed with nursing service personnel. At the time of program initiation in 1980, it was believed that the major focus of increased clinical efficiency, self-confidence, and learning could be achieved best with clients located on the medical-surgical units at Howard County General Hospital. This decision was based on the fact that new graduates hired by the hospital were not permitted to go directly into the specialty areas without a minimum of one year of medical-surgical experience. Nursing service perceived the gap between school and the real world as occurring on the medical-surgical units. However, student requests for additional clinical experience in labor and delivery in 1982 resulted in the extension of the preceptor program into this department.

In addition to type of experiences needed, consideration has been given to the staffing patterns on the individual units and the hospital's commitments to other programs using the clinical facilities. The majority of nursing units at Howard County General Hospital use team leading in delivering client care; only one acute care unit uses a modified primary nursing approach. Patient census on the selected units is considered to be adequate. Since the minimester occurs in January, there is no conflict with other programs.

The preceptor is perceived as a role model, teacher, and evaluator. As a role model, the nurse preceptor demonstrates technical skills, planning and organizational abilities, and priority setting, decision-making, and communication skills over an eight-hour period. As a teacher, the nurse engages in informal teaching skills, such as coaching the student at the bedside, being a role model and resource person, giving positive feedback, and identifying the learner needs. The preceptor is responsible for a written evaluation of the student's clinical objectives, using the form provided by the college. Although the preceptor may assist the students in completing their theoretical objectives, the college faculty is responsible for the evaluation. (To give the staff nurse a baseline of student competencies, a list of laboratory skills each student has completed in the nursing lab is provided by the college. This list is reviewed by the preceptor and student to determine the amount of prior clinical experience.)

The nurse preceptor needs a strong clinical background in medical-surgical nursing and teaching skills geared to the clinical area. This person also needs to be motivated for work in a close one-to-one relationship with a nursing student. Preceptors are accepted who have at least one year of medical-surgical experience, been employed at the hospital for approximately one year, and been recommended by the preceptor's head nurse. Howard County General Hospital provides a preceptor training program for hospital orientation and this program. Basically, the training includes the preceptor's role description, adult learning principles, formulation of goals and objectives, informal teaching skills, and concepts from Kramer's reality shock.

The motivation to be a preceptor is fostered by making the program voluntary on the part of the nursing staff. A notice is placed in the Nursing News, a bi-weekly publication of current happenings at Howard County General Hospital, for nursing staff to contact either the head nurse or staff development coordinator if they are interested in being a preceptor. (An informal presentation was given to the Nursing Management Committee to review the role of the preceptor, clarify responsibilities of the staff nurse, and discuss the time factor involved in preceptorship versus job responsibilities.) Once a list of preceptors is obtained, a schedule of work hours is forwarded to the college faculty for matching of preceptors with students. The Staff Development Coordinator is the official contact person for the program at the hospital.

The hospital recognizes and accepts certain responsibilities in its commitment to the program. First, the preceptor and student must be assigned together. If the preceptor calls in sick and the student cannot be paired with another approved preceptor, then the experience will have to be rescheduled. Second, a reasonable work load will need to be assigned to the nurse preceptor. (At Howard County General Hospital, little change is made from the normal work-day and this does not appear to be a problem.) Finally, the preceptor must not be floated to another unit. Although the student and preceptor could be floated together, it is felt a stable environment is highly desirable for the students to maximize their efficiency and self-confidence. (Initially, some floating did occur. However, communication with the staffing personnel about the program and identification of the preceptors keeps floating to a minimum.)

The literature documents that preceptorships increase job satisfaction, promote personal and professional growth, increase commitments to new graduates, and improve recruitment and retention (Limon, 1982). At Howard County General Hospital, a number of the same staff nurses return each year to volunteer their services as a preceptor. From the viewpoint of one preceptor, the staff nurse becomes actively involved with the students and accepts them as part of the staff by the end of the clinical preceptorship. This support is carried over into the semester that follows the preceptorship. The student is regarded as an individual who needs the support of staff rather than one more student without an identity other than uniform.

In conclusion, a clinical preceptorship is a viable solution to decreasing the gap between school and the real world expectations of nursing service. Students benefit from the increased learning, self-confidence, and efficiency; educators and nursing service benefit from the cooperative effort to ease the transition from academic to practice settings.

AN INTERNSHIP PROGRAM

Frances E. Casillo, Nurse Internship Coordinator, described the internship program at the Medical College of Virginia Hospital (Richmond, Virginia).

Internship programs came into vogue during the early 1960s. Specific purposes, based on the needs of the new graduate and the needs of their institution, may differ. The purposes of Medical College of Virginia (MCV) Hospital's internship program are three-fold: (1) to recruit new graduates to a large, rather complex medical center; (2) to assist the new nurse in the transition from the student to practitioner role; and (3) to retain these nurses for a period of time following their internship year.

The structure of the program is fairly unique. It is a voluntary, 12-month program, offering no academic credit. There is no commitment on the part of the intern to remain at MCV Hospital's facilities following the internship year. The nurse interns function under the same job description as do registered staff nurses. They give direct patient care, administer medications, and act as team leaders or charge nurses. They work 40 hours per week, rotate shifts, and work weekends as scheduled by the units. Following initial orientation, interns are counted as part of the regular staffing of the unit to which they are assigned. The nurse interns receive the same salary and benefits as do other registered nurses.

The five components of the MCV internship program are intended to assist the nurse interns: (1) expand clinical competency, (2) deal with some of the value conflicts that occur when moving from the school to work setting, and (3) become a member of the hospital community. Generalizations about the interns' learning needs cannot necessarily be made according to educational preparation. Therefore, all interns, regardless of academic preparation, participate in the same basic components.

Group Identity and Peer Group Support. This is a significant component of the MCV internship program that is especially important at the start of the program when the interns are new to the work environment, and for those who are also new to the Richmond community. To foster this group cohesiveness, all nurse interns begin employment and classroom orientation on the same date.

Classroom and Unit-Based Orientation. This component of the nurse internship program is not designed solely for the new graduate nurse intern group; the classroom orientation of six days is the same as any new graduate or newly employed RN receives upon entering MCV. The six days are spaced over a two- to three-week period. On opposing days the new employee begins unit orientation. The pieces of the classroom orientation which relate to skill development and nursing care issues are structured in a self-directed, self-paced way. Therefore, individuals whose needs vary

based on their past clinical experiences and educational preparation can proceed at a pace that best suits them. Other classroom learning experiences are provided for individuals assigned to specialty areas. In addition, nurse interns attend the Internship Orientation Day and attend a three-day Basic Personnel Management and Group Process classroom experience. These activities are intended to assist the interns with their team-leading and charge nurse responsibilities.

The length and structure of the Unit-Based Orientation, which the intern receives initially and when rotating to the second unit assignment, will vary, given the unit involved and the individual intern. The orientation focus is on skill development, unit routines, patient care equipment, communication systems, charge responsibilities, and nursing care specific to the unit's patient population.

The majority of the units have a nurse clinician or unit teacher in place. This individual has prime responsibility for planning and coordinating the unit orientation for new staff. She does not function as a preceptor but does serve as a role model and resource person. The nurse clinician elicits the assistance of other members of the nursing staff to implement the orientation plan. Clinical specialists within nursing services may also take an active role in the classroom and/or unit orientation of new staff. The quality of the intern's unit orientation plays a significant part in making a smooth, comfortable adjustment.

Variety of Clinical Experiences. Currently, each intern has two different clinical unit rotations; each is for six months. Areas that are available for the interns vary according to overall needs of the different nursing divisions. Most often, interns are placed on medical-surgical areas, critical care, pediatrics, and psychiatry; occasionally, they are located on obstetrics.

When applying for the internship program, the new graduate indicates on a rotation request form those clinical areas that are of interest. These requests are met as closely as we are able. The majority of the interns choose one general care unit experience and one critical care unit experience; others choose to do two general care experiences.

Continuing Education. Each intern group has six one-day continuing education workshops planned specifically for them. These workshops are in addition to the classroom orientation. The interns complete a learning needs assessment at the beginning of the year, from which topics are selected. The workshops may be clinical or nonclinical in nature. The interns are provided paid work time to attend these events and are awarded continuing education units. The interns, as regular members of the nursing staff, can attend other continuing education events sponsored by the Department of Nursing Education as well as unit-based, in-service activities.

Advisor Support. Each intern has access to a registered nurse advisor throughout the year. The advisor does not function as a clinical instructor or preceptor. Rather, the advisor acts as a resource person for the intern, listens and gives support, helps with problem solving, and arranges conferences with the intern and unit administrative staff. The intern-advisor relationship is not intended to take the place of, or undermine

in any way, the intern's relationship with unit staff. Instead, it attempts to encourage and foster direct communication between the intern and her immediate supervisors.

The advisor makes rounds on the various clinical units to which interns are assigned. These contacts, although informal in nature and sometimes brief, are essential to the development of the relationship. Interns may be seen approximately twice each month, pending need and schedules. It is the responsibility of the advisor and the intern to initiate the contacts.

In summary, the internship is an effective recruitment mechanism. Some individuals learned about MCV as a result of the internship, and began employment as staff nurses. Although we do not have data to prove that interns remain in the setting longer than new graduates who were not nurse interns, the average retention rate of nurse interns, following their internship year, is about 50 percent. In 1982, the rate was probably closer to 75 percent. This increase may be a result of the economy and the tightening job market. Many of the nurse interns remaining in the MCV system have assumed high clinical or administrative positions.

How effective is this program? Evaluations completed by the nurse interns at the six- and twelve-month periods are generally very positive. Although the internship does not eliminate the reality shock phenomenon, the interns readily point out that having the support of a referrent group, an advisor, and interested clinical staff helped them through the stressful times. Some of the graduates said they would not have considered employment in such a large facility following graduation had it not been for the support and experiences offered through the internship program. The learning experiences, both on unit and in the classroom, are almost always evaluated as being beneficial in increasing competency and confidence.

AD/BSN COMPETENCY DIFFERENTIATION

S. Joan Gregory, Associate Professor and Assistant Dean, College of Nursing, University of South Florida (Tampa), discussed the differentation of AD/BSN competencies. Excerpts from her paper follow.

Graduates of basic nursing programs, though prepared for different roles and functions, exhibit exactly the same deep concern, fear, in their first nursing experiences as graduate nurses. Having observed staff nurses with years of nursing practice to their credit and noting the efficient manner in which they handle the technical aspects of nursing, the new graduates compare themselves unfavorably and concentrate on what they perceive to be their own inadequacies. These unfair comparisons prevent them from moving smoothly into the real-world nursing experience.

To make the transition easier, Brunt (1974) reports that a six-week orientation program for associate degree nursing graduates was developed and implemented in one hospital. The program, based on five interrelated roles (provider of care, client teacher, communicator, manager of client care, member within the profession of nursing), was available to five newly graduated associate degree nurses. Using a checklist of 165 items, the program revealed that 162 of the procedures had never been performed by the five graduates; experiences had to be provided in this program. Similar programs have been developed for baccalaureate and diploma graduates. How cost-effective is this practice? Is it cost-effective to develop staffing patterns that are different for graduates, depending on their level of preparation? Is it cost-effective not to develop staffing patterns based on level of academic preparations?

One way to illustrate the differences in role and function in relation to competence, is to look at what has been done in one state as a cooperative effort between nursing education and nursing practice representatives. In response to community needs (DeChow, 1977), a statement of nursing competencies for Associate Degree graduates was developed by the State of Florida nursing educators in collaboration with nursing practice representatives. The document was published by the Florida Department of Education and approved by the Association of Nursing Service Administrators. It was used by the baccalaureate nursing program at the University of South Florida to develop entering competencies for registered nurses who wished to pursue the baccalaureate degree.

A comparison of one of these competencies illustrates the differences:

Competency

Utilizes the nursing process in giving nursing care.

Associate Degree (primarily in secondary care settings with individuals)

Takes nursing history
Assesses patient needs
Develops care plan
Implements according to priority needs
Evaluates and documents according to standards of care
Modifies plan as needed

Baccalaureate (primary, secondary, tertiary care settings with individuals, families, groups of clients)

Establishes a data base through a history and psychosocial-physical assessment
Establishes a nursing diagnosis
Defines goals and develops plan
Implements plan
Evaluates effectiveness

The terminal competencies are the same for both generic and registered nurse students at the University of South Florida; however, the ways in which the competencies are achieved may differ.

Registered nurses admitted to the nursing major at the University of South Florida are evaluated on theoretical and clinical competencies at appropriate stages. Having demonstrated mastery of the associate degree competencies, the registered nurse progresses toward achieving those competencies that have been defined as appropriate for the baccalaureate level. Needless to say, a very critical factor for the faculty is developing accurate evaluation tools and observation procedures to assess achievement of these competencies. For a number of years, it was presumed that registered nurses could perform basic skills competently; however, evaluation indicated a wide variety of performance levels.

The College of Nursing, with the assistance of funding from the W. K. Kellogg Foundation, developed a competency-based curriculum. Evaluation was changed for registered nurses to include clinical performance examinations that are administered at local, participating hospitals. Although all aspects of the evaluation process are related to specific competencies, a variety of methods and tools are used; for example, written examinations, clinical performance examinations, end-of-program evaluation, retrospective evaluation, and follow-up procedures. Of these, the most stressful to students seems to be the clinical performance examination.

Theoretically, the registered nurses are weakest in community, gerontological, psychiatric, and obstetrical nursing. Most of the registered nurses bring to the baccalaureate program a solid base in medical-surgical nursing. Most of the information related to research, leadership, and primary care is new to the registered nurse. Individual assessments determine the focus for particular students. Assignments, written and clinical, attempt to help a student achieve these specific competencies. These findings at the University of South Florida are fairly consistent with those documented in the literature.

What are the implications of these differentiations for education and practice personnel? The implementation of the Diagnostic Related Groups (DRG) will require that all health care workers be apprised of how case-based reimbursement affects them (Grinadli and Micheletti, 1983). The cost of nursing hours must reflect the "intensity of nursing service which patients require, the relation between nursing costs and DRG classification, and the relation between nursing costs and total hospitalization charges" (Riley and Schaefers, 1983). Thus, the quality of nursing care assumes new meanings for graduates of diploma, associate degree, and baccalaureate programs.

The associate degree nurse may need a more narrow scope, but with greater depth. The nurse will need to learn more about assessment, discharge planning, use of resources, organization, and prioritization to be able to help clients determine health care goals and provide instruction in self-care.

OPPORTUNITIES FOR SUCCESS IN THE 80s

Katherine Vestal, Associate Executive, Hermann Hospital (Houston, Texas), spoke to the myths and realities of nurse utilization in an area that is changing daily.

The health care environment is currently undergoing incredible changes. The rapidity of these changes makes both education and practice more difficult, because both are much more difficult to define and predict.

The chaotic state of the health care environment is good news and bad news. The bad news about this chaos is that it makes predicting and planning for the future very difficult. With the advent of cost regulation by the government and the pressures to improve delivery systems at reduced cost, the area of manpower needs has become blurred. Will the utilization of the RN increase or decrease? What will the role of the nurse become? Approximately 40 RNs equal $1 million in payroll. With the pressure to reduce costs, it can be seen all over the country that the number of RN positions has declined. If this is a trend, the reduced RN ratios will dictate a close look at roles in each institution. A clear definition of roles and functions will be a necessity when justifying multimillion dollar budgets in nursing.

Another aspect of the new environment is the era of competition that has emerged. There are certainly many good things that result from competitive services, but the rapid increase in the types of new services has created businesses that are questionable in terms of both quality and distribution. Examples of the growth in health care delivery sites are the increase in proprietary hospitals, shopping mall health centers, free-standing surgical centers and birthing centers, etc. These are clearly practice sites for the AD graduates.

The impending physician oversupply is also an area to consider. The 1980 GEMENAC report predicted an overabundance of physicians in many specialties by 1990. However, there has been little response from the medical community to reduce physician production. Thus, their oversupply will have an impact on nursing roles in the future, particularly in alternative delivery systems.

What is the good news? There are many good things to come out of the new health care environment, especially for nursing. The chaos will engender changes, and if properly guided, the change could be positive for nursing.

Obviously, the most positive aspect of the change is that patient care is again fashionable. The very basis of the educational program is emerging as the most important aspect of managing patients. However, if funding for a patient's problem is predetermined, as with the DRG Prospective Payment System, the management

of the patient must be efficient and effective in order to be cost-effective. The only person on the health care team that manages patients 24 hours a day, seven days a week, is the nurse. Thus, the nurse will become the primary professional in managing the entire scope of the patient's care.

If nurses in the care delivery business can get their act together, they can emerge as a dominant force in institutions. They will be rewarded for thinking, questioning, delivering, and improving all aspects of care. This will be possible if nursing services are aggressive and creative, and if nurses are educated and reeducated to be on the cutting edge of practice.

Another area of good news is that new problems have created a need for new solutions. We have proven that our old ways of doing things didn't necessarily solve issues. Thus, the nurse must begin to see her role as an initiator, a creator, an innovator, and a problem solver, both for her patients and the institution. This is incredibly exciting! How can nurses improve care, reduce redundancy, streamline services, and create new ways of doing things? The nurse of the future must see this as her role.

An example of a field that is wide open for such innovation is in the care of the elderly. A long neglected population, this group, by sheer numbers, will force attention to solving their health care problems. A 50 percent increase over the next 10 years is anticipated; yet response is slow. Nursing is in an ideal position to initiate many of these sorely needed services.

The competitive market creates opportunities for the ADN nurses of the future. The whole field of marketing--both services and image--is an area nurses are involved in. New language and new behaviors are required to discuss health care in terms of market share, customers, and market responsive services.

As indicated earlier, the health care environment is undergoing very rapid change. The social issues will be heavily debated, the technological issues will be critical, and the human touch issues must still be integrated. How can we produce a nurse who will find nursing in the future to be a challenging and rewarding career?

More nurses want to develop careers rather than just to perform jobs. Their aspirations are high. They want to contribute, to make a difference, and to feel rewarded for their involvement. All the money in the world can't buy that--it must be the product of a good fit between the graduate and the work place.

Employers need graduates to fulfill many roles (obviously on different levels as they mature professionally). Among these roles are: clinician, educator, researcher, manager of patient care, business person, politician, negotiator, initiator, entrepreneur, futurist, and writer. The nurse is not a purist. Nurses are integral parts of health care organizations. Obviously, service and education personnel share in the responsibilities to the new nurse. The graduate nurse will benefit from service and education personnel talking about the process and the product.

Education and service have both reached a point where a marriage is in order. They can collaborate, from the point of a student admission to several years following graduation, about issues relevent to both education and practice. For example, it is a known fact that education prepares a person to function as a direct caregiver in the in-patient setting. In reality, the graduates do it all, from caregiver to directors of nursing. If this is a reality, how can education and service work together to resolve the issues?

Nursing service can provide an internship for graduates at considerable expense; however, only a fraction of graduates may have an opportunity for an internship. The realities of practice hit hard; the losses are sometimes great as new nurses leave the profession before they really develop a sufficient level of self-esteem to feel comfortable in their role as nurses. These realities may be addressed best prior to graduation, through collaboration between service and education.

Likewise, many new avenues for practice are opening up. Health care that is provided in the shopping malls, offices, and other places will require different types of preparation. While on-the-job training has always been a reality of doing business, it may be that the demands of the market place will require adaptations in education.

In summary, the nurses of the future must indeed be "he nurses" and risk-takers. Educators and employers must help them to think differently, to expand their view of health care issues, and constantly reach into the future.

CLINICAL COMPETENCE VALIDATION

The "pearls, perils, and pitfalls" of validating clinical competence of AD students were addressed by Carol Singer, Director, and faculty members of the Associate Degree Nursing Program at North Harris County College (Houston, Texas). A synopsis of the method used at North Harris County College follows.

The basis for the conceptual framework in nursing at North Harris County College is an integrated curriculum founded on the belief that man is a total being, a viable composite of many parts continually interacting with his environment. Man's responses to his environment are incorporated into four major areas: perception, cellular metabolism, transport, and fluid and electrolyte balance. The relationship between human needs and nursing actions in wellness and in illness for all age groups is emphasized in the five nursing courses (Nursing I - Nursing V).

The faculty believe that an integrated curriculum is a systematic approach to learning based in specific measurable objectives that progress from the simple to the complex. The focus is the use and application of broad principles to the solution of specific problems. This focus eliminates repetition and allows for a more economical

use of the learner's time. The unifying themes of this conceptual framework include: (1) the needs of the individual throughout the life span, (2) man's response to the environment, (3) identification of man's place in the community and its influence on the resolution of his health problems, (4) the nursing process (problem-solving approach), and (5) the nurse as a member of the health team.

Observation, question-answer, or review of student charting are means faculty use to validate clinical competence. Students must demonstrate specific behaviors during a clinical performance examination at the end of a semester. The examination is administered from 7:30 a.m. until 12:00 noon by a faculty member who is not the usual instructor. The examiner selects clients who have health problems that relate to some disturbance or disease that has been studied during the semester. Clients may be chosen from medical, surgical, pediatrics, or post-partal areas.

A sample of the evaluation tool used in Nursing 291 (Nursing IV) follows:

I. Assessment

A. Observes signs and symptoms, interviews the client and/or family, reviews chart and diagnostic procedures.

B. Identifies subjective and objective data based on the assessment related to:

1. admitting diagnosis
2. current problems
3. learning needs

II. Identification of Problem

A. Determines and states problems in order of priority by consideration of:

1. Maslow's hierarchy
2. Client preferences
3. Treatments, medications, tests (when a time frame is necessary)

III. Planning/Implementation

A. Administers nursing care based on priority.

B. Performs nursing measures consistent with doctor's orders, nursing orders, hospital policy and procedure manual, use of scientific principles, the North Harris County College medication policy, and required time frame.

C. Uses communication skills based on critical elements:

1. Calls client by name
2. Utilizes techniques to encourage purposeful conversation
3. Responses are related to client's response
4. Modifies environment to promote conversation
5. Correlates own verbal and nonverbal behavior
6. Listens attentively
7. Reports and records appropriate information in correct format

D. Administers medications by intramuscular or subsutaneous route

1. Observation of the five rights
2. Calculation of dosages

E. Regulates intravenous infusion rates correctly

F. Maintains client safety

1. Protects from environmental hazards
2. Protects from emotional hazards

IV. Evaluation

A. Modifies priorities in plan of care and nursing actions according to client's response.

B. Charts pertinent information (format that meets acceptable legal requirements)

The students are expected to demonstrate competence in the above areas. They are not expected to perform any treatment that occurs unexpectedly during the examination or not performed on a prior occasion in the clincial area. Textbooks and procedure manuals can be used as resources during the examination. The examiner informs a student of the results of the examination in a clinical evaluation conference. (The dates for the examination and conference are posted at the same time.)

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